Business Planning

MHS Goals

Improve service to external customers: Our customers are the Armed Forces and all those entrusted to our care.

Enhance financial stewardship: Accomplish our mission in a cost effective manner that is visible and fully accountable.

Improve Readiness: Focus on activities to enhance readiness of military forces and the medical assets that support them.

Improve Quality: Ensure benchmark standards for health and health care are met.

Improve Efficiency: Obtain maximum effectiveness from the resources we are given.

Value our internal customers and leverage technology: Our people and our support systems are critical to giving us the capabilities to execute on all we set out to achieve.

External Forces - Cost of Health Care

- Increasing demand
- Increasing technology
- Better, but costlier, pharmaceuticals
- Health care costs skyrocketing
  - Consuming larger percentage of nation's GDP
    - **14.1% in 2001 vice 13.3% in 2000**
    - **Projected to increase to 17.7% in 2012**

External Forces - General Economic Conditions

- Increasing civilian health plan costs
  - Premiums
  - Deductibles
  - Co-pays
- Higher unemployment rates
- TRICARE becoming health plan of choice
  - Increasing number of users

Internal Forces - T Nex Policy Changes

Streamlined Private Sector Care Contracts

- No more O-Factor
- Price tied directly to claims cost

Revised Financing for Direct Care System

- All MTFs now responsible for purchased care delivered to their enrollees

Incentive to push care to MTFs

- MCSC Contractors retain 20% of value any planned care provided by MTF's.

Aligning Financial Incentives Oversight and Performance

- Forecast direct care system health care outputs and purchased care requirements
- Coordinate care in multi-service markets and regions
- Use prospective payment to place accountability for care at MTF
- Services explain deviations from plan and initiate management action to work within available resources

Prospective Payment Concept

(Output-Driven Resource Allocation Concept)

- Base health care portion of the direct care system budget on output, not input
- Based on value of MTF business plans
  - Capitated rate for enrollees
  - Fee for Service rate for “Space Available” care
- Rates based on price at which care can be purchased
  - CMAC rates
  - Not MTF costs
- Computed at MTF level but allocated to services

Valuation of Business Plans

- Capitation Rate
  - Adjusted for Age Group, Gender, and Bene Category
  - Utilization x Price
  - Using DoD average utilization
  - Prices based on geography
- Fee for Service Rate
  - Based on average amount allowed
  - Adjusted for geography

Output Driven Resource Allocation

Basic Equation

Capitated Payment based on Enrollment at MTF

—

Fee for Service Payment for MTF-enrollee care delivered by MCSC

—

Fee for Service Payment for MTF-enrollee care delivered by other MTFs

+

Fee for Service Payment for non-MTF-enrollee care delivered at the MTF

=

Business Plan Value

Output Driven Resource Allocation Benefits

- Capitation rate encourages appropriate utilization and demand management
  - Discourages “churn and earn”
- Fee for Service rate encourages maximum use of MTF
  - Consistent with Contractor incentive
- Using value vice cost makes Direct Care and Purchased care comparable
- Separating health care allows clearer visibility of non-health care costs
  - GME
  - Readiness

Prospective Payment Concept Phase-In

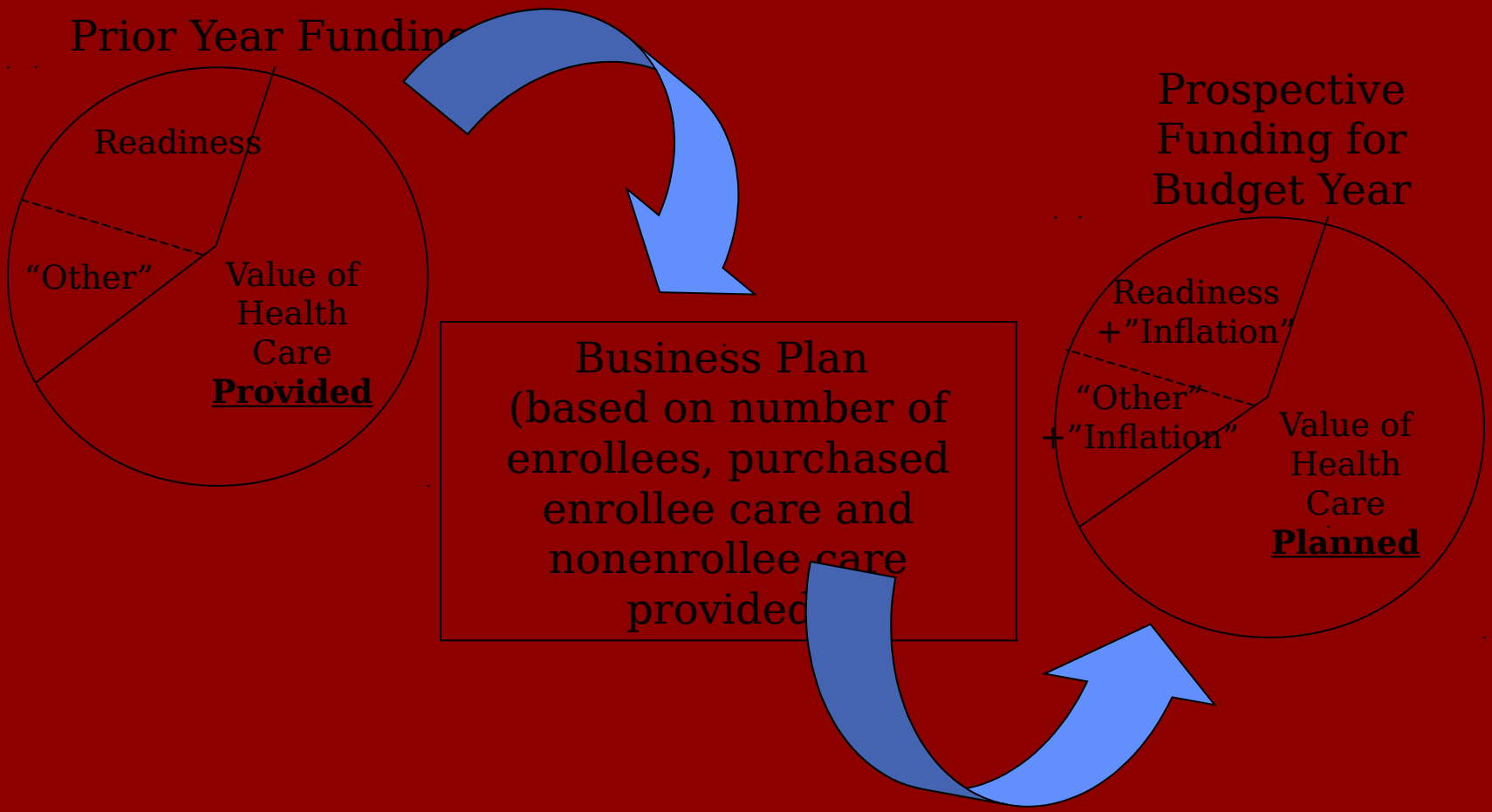
- System will be phased in over 5 years
  - Shadow in FY04
  - 25% prospective payments in FY05, 100% in FY08
- Allows for adjustment in methodology
- Provides learning curve to MTFs
- Limits shock to the system

Why Business Plans and New Resource Allocation Method?

- Need to be able to forecast health care needs and purchased care requirements
- Coordinate care in multi-market regions
- Place accountability for care at MTF
- Be able to explain deviations from plan
- Base budgets on outputs, not inputs

Output Driven Resource Allocation

Effects of Business Plans on Direct Care Budgets


Prior Year Funding
Readiness
"Other"
Value of Health Care **Provided**
Business Plan (based on number of enrollees, purchased enrollee care and nonenrollee care provided
Prospective Funding for Budget Year
Readiness +"Inflation"
"Other" +"Inflation"
Value of Health Care **Planned**

- Budgets will be reconciled based on performance a

MTF Business Plans

Starting with historical levels, MTFs will create business plans based on a standard template (handouts) and using standard measures to answer the following business questions:

- How many people do you expect to enroll?
- What amount of health care do you expect your enrollees to demand?
- What amount of health care do you expect your facility(s) to produce? What amount will be for non-enrollees?
- How are you going to meet the demands of your enrollees for health care that you can not provide?
- What manpower resources will you have to produce health care?
- What other major changes in your facility(s) will affect the amount of health care you produce?

MTF Business Plans
Planning behind the Templates

Business Plan templates are only the end result of health care

planning:

- Are there changes in the population in the MTF area?
  - Unit movements
  - Retiree Marketing
  - End result: Changes in Enrollment
- Are programs being instituted for Utilization/Demand Management?
  - Nurse Triage
  - Discharge Planning
  - End Result: Changes in Enrollee Demand

MTF Business Plans
Planning behind the Templates

Are there changes in the manpower being assigned?

- Loss of providers
- Closing of Services
- New civilian hires
- End result: Changes in FTEs, changes in Workload

Are programs being instituted to improve clinic efficiency ?

- Open Access
- Increase in exam rooms
- Increase in support staff
- End Result: Changes in Enrollment, Workload

Are programs being instituted to manage referrals?

- End Result: Shift in Workload from enrollee purchased care to enrollee MTF care

Importance of Business Plans

Well thought out, developed Business Plans essential needed for:

- MHS Strategic Plan
- Government and DoD-wide policy
- T Nex administration and governance
- **Budget formulation and justification**
- **Output Driven Resource Allocation**

Your Areas of Concerns

Enrollment Optimization

Referral Processes

Case Management / Utilization Management

Make-Buy Decision Capability

Tracking PSC Deployment Costs

Questions ??

Market Management and Business Planning:

A Conceptual Framework for Preparation and Analysis

Assumption: Bottom Line Reality

We are not in business to make a profit but:

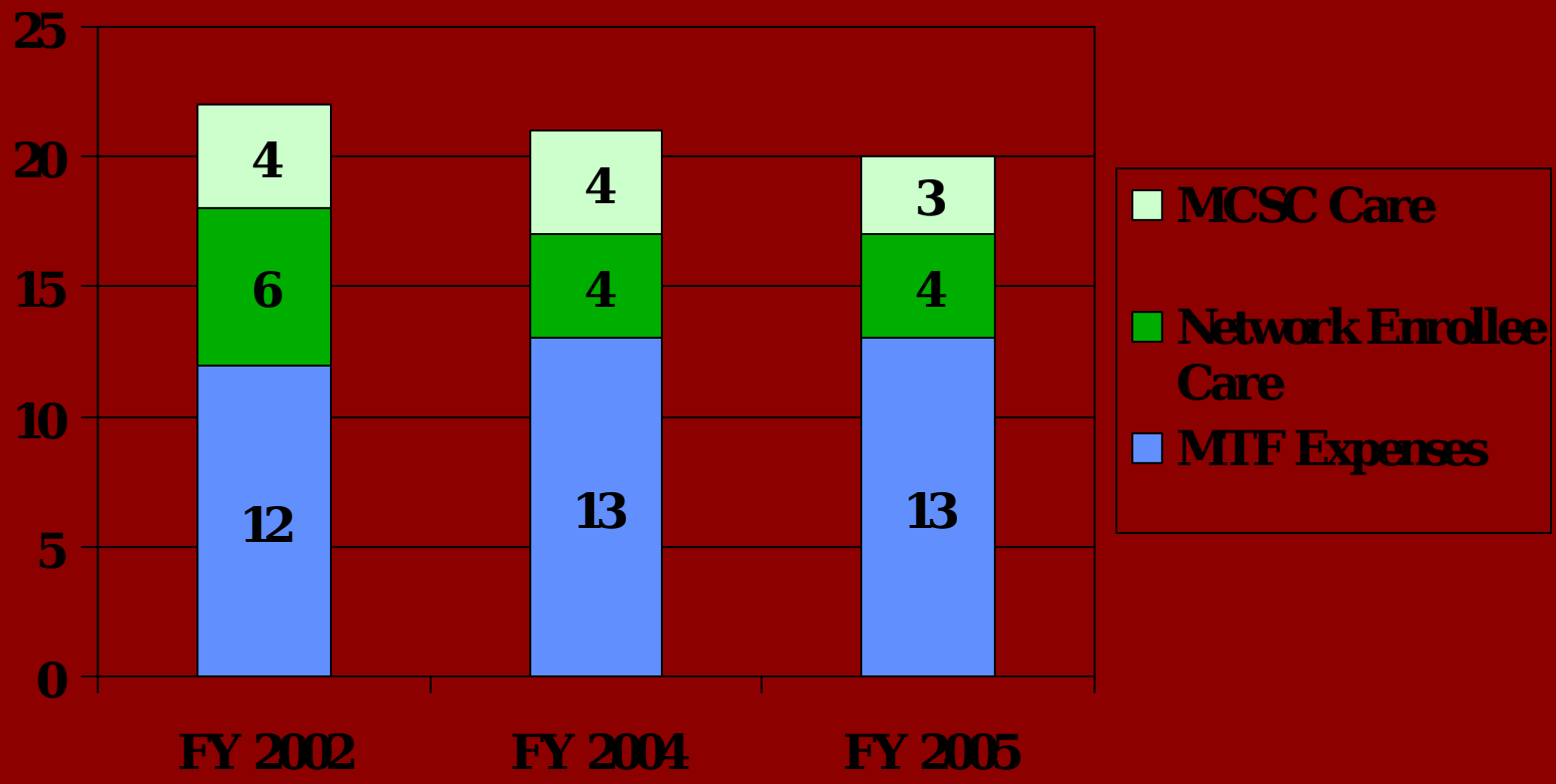
If we do not produce our services at a cost to the government that is comparable to civilian benchmarks, then we will not be in business.

Benchmarks: Expense/RVU, CMAC per CPT, Expense per RWP, Total Expense per Enrolled Beneficiary (PM/PM)

Market Healthcare Expenses (under T NEX)

Where do we need to focus our optimization effort
What should this MTF concentrate on?

Success in T NEX



What do we use “resource sharing” for?
How do we benefit by reducing the MCSC at risk c
What kind of a market/facility might this represent

Major Strategic Objectives Under T-NEX

- Optimize Enrollment
- Optimize Capacity for Health Care Delivery
- Refine Core Businesses
- Integrate with Military and Civilian Health Care Providers

Capacity (Ability/Capability)

- Clinical Production – Visits, OBD's
  - Available Appointments, Staffed Beds
- Clinical Production – RVU's,RWP's
  - Acuity Adjustment
- Clinical Outcomes – HEDIS Measures
  - Not available.
- Enrollment – Covered Lives
  - May not want to "maximize".
- Space A Care - # of Users
  - Balance with enrollees.

Capitation or Fee for Service? Both?

- Capitated method for Enrollees
  - Goal – Reduce cost per enrollee per year to produce a “profit”
- Fee for Service for all Non-Enrollees
  - Other MTF’s Enrollees
  - MCSC Enrollees
  - Over 65 Care
  - Goal – Reduce cost per RVU to produce a “profit”.

Benchmark Capitation Rates

- 580 Health Care Systems/HMO's participated in the survey.
  - Benefits were different.
- Global Coverage Commercial PMPM
  - $126.21 Average ($84.00-$157.28)
- Global Coverage Medicare PMPM
  - ~$401 Average ($303-$401)

Source: 2002 Capitation Survey, National Health Information, LLC

How are Commercial (Under 65) Capitated Expenses Distributed?

	Average	Low	High
Physician Primary Care	13.41	10.31	19.24
Physician Specialty Care (OP and IP)	37.05	18.33	49.93
Hospital Services	53.15	28.03	91.52
Total	126.21	112.09	157.28

How To Capitation Rates To Assist Command in Determining Optimal Enrollment

- Example: Small MTF with Only Primary Care
- 12,500 Enrollees
- Operating Budget of 14.8 Million (incl. MILPERS)
- Network Costs – 6.4 Million
- Cost of care provided by other MTF's - ??
- 80% of Care is for Enrollees

Calculating the Expenses incurred for Enrolled Beneficiaries at an MTF

Type of Expense	Amount
Total “Budget”	21.3
Subtract Network Care	6.4
Subtract Readiness	0.57
Subtract Special Programs	0.71
Subtract Network Pharmacy, Lab, X Ray	1.2
Clinical Expenses	12.4

Adjust for percentage of care delivered to enrollees

12.4 Million * 79% = 9.8 Million

Where Can We Find Cost of Network Care?

Tmt Clinic Svc	FCCA

FY	Direct Exp	Ancillary Exp	Support Exp	Total Exp
2001	$5,370,800	$1,221,081	$0	$6,591,881
2002	$6,480,573	$1,070,202	($5)	$7,550,769
2003	$2,474,806	$166,034	$0	$2,640,840
Grand Total	**$14,326,178**	**$2,457,317**	**($5)**	**$16,783,490**

Source: M2 – MEPRS FCCA-CHAMPUS Beneficiary Support

Expense for 12,500 Enrollees

	OP Expenses	IP Expenses
MTF	9.7	0
Other MTFs	??	??
Network	3.5	2.9
	>13.2	>2.9

How is this MTF/Market Manager doing with regard to the expense PMPM?

- 13.2 for OP and 2.9 for IP and “For other MTF Care” ? = > 16.1 Million
- 16.1 million/12,500 = $1288 per member per year
- $1288 PMPY/12= >$ 107 PMPM
- What do you think?
  - Global Average $126.
  - How much is being done by other MTF’s?

Utilization for 12,500 Enrollee

	OP Visits	IP Admissions
MTF	62,748	0
Other MTFs	14,740	184
Network	25,475	662
Total	102,963	846

Utilization Benchmarks - Some Basics

	Average	Low	High	Median
Visits / 1000 /year Primary Care	2736	2352	3396	2736
Visits/ 1000/ year All Care	4836	3576	5304	4596
Admits/1000/ year	54	47	64	53
Length of Stay	3.85	3.2	4.8	3.8

Utilization Benchmarks – How do we compare?

	Commercial Average	Commercial High	MTF FY 2002 Actual
Visits / 1000 /year Primary Care	2736	3396	
Visits/ 1000/ year All Care	4836	5304	8237
Admits/1000/ year	54	64	61.6
Length of Stay	3.85	4.8	4.1

How Much Space Available Work Do You

Enrollment Site Parent Name2	Data	Total	Percent of Total
MTF Enrolees	Sum of Visits, Raw	62,748	79%
	Sum of Simple RVU, R	52,049	78%
Standard	Sum of Visits, Raw	11,340	14%
	Sum of Simple RVU, R	9,868	15%
Other MTF Enrollees	Sum of Visits, Raw	5,385	7%
	Sum of Simple RVU, R	4,830	7%
Total Sum of Visits, Raw		79,473	100%
Total Sum of Simple RVU, Raw		66,746	100%

Source: M2 FY 02

How Much OP Work is Done by the Contractor?

*Enrollment Site Name(Query 3 with ARSBSP2)2	Number of Visits, R	RVU, Simple, Raw	Amount Allowed, Ra
(blank)	49,483	56,098	$7,747,093
Our MTF	24,958	41,081	$4,604,549
ANDREWS AFB - 89TH MED GRP	1,572	2,608	$267,584
ANDREWS 89TH MED GRP TSC-PCM	1,060	934	$119,719
NNMC BETHESDA	157	255	$34,263
MANAGED CARE CNTRCTR-REGION 01	256	169	$21,737
Other MTF Enrollees	**749**	**1,092**	**$126,634**
Grand Total	**78,235**	**102,238**	**$12,921,581**

Source: M2 FY 2002

We need to look at the efficiency of our internal operations.

How can we assess our internal efficiency?

Core Clinical Activities – Value Producing Activities (Note: Ancillary codes also produce clinical value: lab, pharmacy, or radiology)

Tmt Clinic Svc	Service Name	Average of Available Providers	Average of Available Support Staff	Total Visits	Adjusted RVU, Raw	Average of RVU/8H of Provider Time	Total Expense Less Ancillary
BAAA	INTERNAL MEDICINE CLINIC	1.3	2.0	3,978	2,720	8.7	$376,877
BAFA	ENDOCRINOLOGY CLINIC	0.0	0.0	0	1,404	#DIV/0!	$8,180
BCBA	GYNECOLIGICAL CLINIC	0.9	0.8	4,044	2,505	9.6	$331,507
BDAA	PEDIATRICS CLINIC	1.8	3.0	8,027	4,839	12.0	$588,402
BFDA	MENTAL HEALTH CLINIC	3.6	1.3	2,630	6,128	6.7	$605,963
BFFA	CAAC	0.0	4.5	2,707	4,389	#DIV/0!	$366,320
BGAA	FAMILY PRACTICE CLINIC	5.8	17.7	25,777	15,644	14.2	$2,329,085
BHCA	OPTOMETRY CLINIC	1.6	2.2	3,747	4,824	14.4	$458,711
BHGA	OCCUPATIONAL HEALTH	0.9	5.0	3,114	2,803	12.0	$691,514
BJ AA	MILITARY MEDICINE CLINIC	5.5	15.6	14,957	12,947	9.5	$2,110,798
BLAA	PHYSICAL THERAPY CLINIC	0.0	3.1	3,925	2,591	#DIV/0!	$286,055
Grand Total		**1.7**	**4.4**	**72,906**	**60,793**	**10.9**	**$8,153,482**

Is each of these activities consistent with and critical to success of the MTF strategic plan?
Is the efficiency in each unit optimized?

Provider Productivity Benchmarks

What are some Measures ?

- Visits per Provider per Year
- Work RVU's per Provider per Year
- Work RVU's per 8H of Provider Time

RVU's Per Provider Per Year

Specialty	Mean RVU's per Year	75th Percentile	90th Percentile
Family Practice (with OB)	4350	5107	6105
Internal Medicine	3917	4565	5452
Pediatrics	4044	4862	5637
Orthopedics	7229	8756	10601
GI	7310	8140	10667
General Surgery	6365	7691	9433

Source: MGMA Academic Practice Compensation and Production Survey 2001

RVU's Per Provider Per Day

Specialty	Mean RVU's per Year	75th Percentile	90th Percentile
Family Practice (with OB)	19.7	23.2	27.7
Internal Medicine	17.8	20.2	24.7
Pediatrics	18.3	22.1	25.6
Orthopedics	32.85	39.8	48.1
GI	33.2	37	48.5
General Surgery	28.9	34.91	42.8

Source: MGMA Academic Practice Compensation and Production Survey 2001

How Do We Improve Internal Efficiency ?

- Improve Data Quality
- Appointing Optimization
- Staffing and Competency Optimization
- Judicious use of “resource sharing” which is really “resource augmentation”.
- Use Benchmarks

What should our MTF do?

- Where should enrollment be?
  - Focus on AD, ADFM and selected retirees.
- What critical services must be available to manage the care of enrollees in the network?
  - Case Managers, Population Health/Managed Care Office.
- How can the MTF shift care from the network to other MTF's in order to optimize the MTF and reduce the enrollee network expense?
  - Develop a more formal relationship with the hospital and OP clinics that do most of the Network Care. Ensure that MTFs have first right of refusal for IP care.
- What can the MTF do to reduce unnecessary OP care.
  - First determine source of the apparent over-utilization. Target population of high utilizers or look for providers who make many referrals.
- What can the MTF do to increase provider productivity
  - . Set goals, monitor performance, ensure access.

Questions?